PROPOSAL FOR A SECTION 1915(b)(4) Initial Selective Contracting Waiver Program

Waiver Application Form

I. INTRODUCTION

On Appendix I, please provide a short narrative description, in one page or less, of your program, the background to your program and any other information relating to your request for a Medicaid waiver.

II. GENERAL DESCRIPTION OF THE WAIVER PROGRAM

A. **The State of** **Tennessee** requests a waiver under the authority of Section 1915(b)(4) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

B. **Effective Dates:** This waiver is requested for a period of 2 years; effective July 1, 2002 and ending June 30, 2004 .

C. **The waiver program is called** TennCare for Medicaid/Medicare Duals .

D. **Geographical Areas of the Waiver Program:**
The waiver will be implemented in the following areas of the State:

(1) ___X_____ Statewide

(2) _____ Other-than-Statewide (Cities and Counties are Listed on Appendix II.D.(2))

(Note: if the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification must be submitted to HCFA.)

E. **State Contact:** The State contact person for this waiver is Manny Martins and can be reached by telephone at (615)741-0213 .

F. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(4) of the Act** under which the State restricts the provider from or through whom a recipient can obtain medical care.

G. Relying upon the authority of the above section(s), the State would like a

waiver of the following Sections of 1902 of the Act:

1. ___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State. (See Appendix II. D.(2))

2. ___ ***Section 1902(a)(10)(B)*** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in the waiver program.

3. _X_ ***Section 1902(a)(23)*** - Freedom of Choice--This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals in this waiver are constrained to receive waiver services from selected providers.

4. ___ **Other Statutes Waived** - In Appendix II.G.4, please list any additional section(s) of the Act the State requests to waive, including an explanation of the request.

H. Recipient Figures: Please indicate the expected number of Medicaid recipients that will be impacted by the waiver: approximately 170,000 Medicaid/Medicare dual enrollees

I. Waiver Populations: The waiver is limited to the following target groups of recipients. Check all items that apply:

1. ___ **AFDC** - Aid to Families with Dependent Children.

2. __ **AFDC-Related**

3. ___ **SSI** - Supplemental Security Income and SSI-related.

4. _X_ **Other** - Please describe these other populations on Appendix II. I.4.

J. Excluded Populations: The following recipients are excluded from participation in the waiver:

1. ___ have Medicare coverage, except for purposes of Medicaid-only services;

2. ___ have other insurance;

3. ___ are residing in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

4. ___ have an eligibility period that is less than 3 months;

5. ___ have an eligibility period that is only retroactive;

6. ___ are eligible as medically needy;

7. ___ are eligible as foster care children;

8. ___ participate in a home and community-based waiver; or

9. ___ have other reasons which may exempt recipients from participating under the waiver program. Please explain those reasons on Appendix II.J.9.

K. Distance/Travel Times: On Appendix II. K., please define your access standards for distance/travel times for recipients to receive services.

L. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on recipient access to care of adequate quality. **This assessment is to be submitted to CMS 3 months prior to the end of the waiver period**. Entities that may perform the assessment include universities, actuaries, etc. Examples of independent assessments are available upon request.

M. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C; 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

III. PROGRAM IMPACT:

In this section, please provide information on (1) affected recipients, (2) services, and (3) waiver providers.

A. Affected Recipients

1. Notification Process: On Appendix III. A. 1, please explain in detail the process through which recipients will be notified of the waiver program provisions.

2. Recipients Choice of Providers. If more than one provider is selected per geographical area, please address the following points on Appendix III. A. 2: See Appendix III.A.2.

(a) Will recipients be given the choice of selected providers? If so, how will they select a provider, and how will the provider be informed of the recipients choice?

(b) How will beneficiaries be counseled in their choice of waiver providers?

(c) How will the recipient notify the State of provider choice?

(d) Define the time frames for recipients to choose a waiver provider.

(e) Will the recipients be auto-assigned to a waiver provider if they do not choose? Yes ____ No ____

(i) If so, how many days will they have to choose?

(ii) Describe the auto-assignment process and/or algorithm.

3. Implementation Process

(a) Will implementation occur all at once?

__X__ Yes

____ No. please describe on Appendix III. A.3.(a) the time frames for implementation, including time frames for inclusion of current Medicaid recipients.

(b) Will there be accommodations for special-needs populations such as the disabled, etc.?

_X__ Yes. Please explain on Appendix III. A.3.(b).

____ No

4. Education Materials: Please include on Appendix III. A.4 all relevant

recipient education materials, including the **initial notification letter** from the State. Also, check the items which will be provided to the recipients:

a. ___ a **brochure** explaining the program

b. ___ if more than one provider is selected per geographical area, a **form** for selection of a provider

c. ___ if more than one provider is selected per geographical area, a **list of qualified providers** serving the recipient's geographical area;

d. ___ a **new Medicaid card** which includes the provider's name and telephone number or a **sticker** noting the provider's name and telephone number to be attached to the original Medicaid card (please specify which method);

e. ___ **a brief presentation and informing materials** to each new recipient describing how to appropriately access services under the waiver program, including the appropriate usage of emergency rooms and family planning services, and how to exercise due process rights; and

f. X___ other items (please explain on Appendix III. A. 4.f.):

5. Languages. The State has made a concerted effort to determine if and where significant numbers (10% or more) of non-English speaking recipients reside, and has subsequently made the program educational materials available in the native languages of those groups.

B. Services:

1. Description of Services:

Please identify the Medicaid services which will be affected by the selective contracting process:

The only services to be covered under this waiver are services covered by Medicaid which are not covered by Medicare. See Appendix III.B.1.

If additional space is needed, please create an Appendix III. B. 1.

2. **Emergency and Family Planning:** In accordance with regulations, freedom of choice of provider in cases of emergency and family planning services will not be restricted.

C. Selection and Availability of Providers (See Appendix C)

1. **Selection Criteria:** On Appendix C. 1, please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Included are the approximate weight associated with each of the criteria.

2. **Numbers and Types of Qualifying Providers:** For each of the services covered by the selective contracting waiver, please list on the chart below the numbers of Medicaid providers available to provide services to the waiver population. The chart also compares the number of providers expected under the waiver with what existed prior to the waiver.

   For non-institutional services provided by an Aentity≅ (i.e. versus an independent practitioner), please provide information on Appendix III. C. 2. as to the numbers of actual care givers per entity that will be available to provide the waiver service(s).

SERVICE: The provider types and the numbers of participating providers are exactly the same in the state's 1915(b) waiver as they are in the state's Section 1115(a) waiver.

Provider Types	Number of Medicaid Providers Participating Before the Waiver	Number of Medicaid Providers Expected to Participate Under the Waiver
1.		
2.		
3.		
4.		
5.		
6.		

3. **Program Requirements.** Below is a description of provider qualifications and requirements under the waiver. Providers **must**:

   a. **be Medicaid qualified providers** and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of service and meet general qualifications for enrollment as a Medicaid provider;

   b. **not refuse to provide services** to a waiver participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type; and

   c. **other qualifications (explain on Appendix III. C. 3. c):**

4. **Provider/ Beneficiary Ratio:** Please calculate and list below the expected average provider/beneficiary ratio for each geographical area or county of the program, and then provide a statewide average.

   The expected average provider/beneficiary ratio for each geographical area of the program, as well as the statewide average, are exactly the same in the state's 1915(b) waiver as in the state's Section 1115(a) waiver.

Area (City/County/Region)	Provider-to-Beneficiary Ratio	
	Without the Waiver	Under the Waiver

Statewide Average: (e.g., 1:500, 1:1000)

5. **Change of Provider:** Please answer the following questions regarding beneficiary changes of providers and/or actual care givers:

   a. Change of Providers:

      If there is more than one selected provider per geographical area, can the beneficiaries change providers?

      ____ No

      ____ Yes . Please describe on Appendix III. C. 5. a. the process, reasons, etc.

   b. Change in Actual Care Givers:

      (I) For non-institutional waiver services provided by an Aentity,≅ can the beneficiaries change their individual care givers within the selected provider?

      ____ No

      ____ Yes . Please describe on Appendix III. C. 5. b. the process, reasons, frequency, etc.

6. **Provider's Change of Beneficiary:** Please answer the following questions regarding provider changes of beneficiaries: (N/A)

   a. If more than one provider is selected per geographical area, can providers request to reassign a beneficiary from their care?

      No _____

      Yes ____

      If yes, **it is important that reasons for reassignment are not discriminatory in any way toward the patient**. In cases of beneficiary change, the reassignment should be agreed upon by the beneficiary as well. The following are acceptable reasons for reassignment. Please check the ones that apply to the State's program and explain those that differ:

      (1) ___ patient/provider relationship is not mutually acceptable;

      (2) ___ patient's condition or illness would be better treated by another provider type; or

      (3) ___ Other reasons (explain on Appendix III. C. 6.a):

b. **If the reassignment is approved,** the State must notify the beneficiary in a direct and timely manner of the desire to remove the beneficiary from his/her caseload, and must keep the participant as a client until another provider is chosen or assigned. Please specify on Appendix III. C. 6.b. if the State's policy differs in any way from those listed above.

7. **Reimbursement of Providers:** Under this waiver, providers are reimbursed on the following basis:

_____ fee-for-service

_____ capitated

Effective July 1, 2002, Managed Care Organizations will be reimbursed on an administrative fee basis. Payment for claims will be made on a fee-for-service basis (fees to be established by the MCOs) and will come from a pool established by the state. Behavioral Health Organizations will continue to be reimbursed on a capitation basis, subject to a global cap. The Dental Benefits Manager will be reimbursed on an Administrative Services Only basis, with claims being paid on a fee-for-service basis. Pharmacy providers working with the state's pharmacy program are paid on a fee-for-service basis.

IV. ACCESS TO CARE AND QUALITY OF SERVICES:

A. **General:** The beneficiary's access to quality medical services must at a minimum not be adversely affected by a 1915(b)(4) waiver program. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency services and family planning services must not be restricted.

B. **Grievance Process:** On Appendix IV. B., please describe the process that will be in place to handle complaints and grievances under the waiver program. Please discuss how this will compare to the regular Medicaid program. **NOTE: Beneficiaries must have available and be informed of a formal appeals process under 42 CFR Part 431, Subpart E which may lead to a Fair Hearing.** Please fully describe on Appendix IV. B.

C. **Monitoring Access:**

1. **Service Access Areas:** On Appendix IV. C. 1, please explain in detail the State's plans to monitor and improve the following areas of service access:

   a. time and distance

   b. waiting times to obtain services

   c. provider-to-beneficiary ratios

   d. beneficiary knowledge of how to appropriately access waiver services

   e. access to emergency services

2. **Procedure for Monitoring:** Beneficiary access to care will be monitored during the waiver period by the State as indicated below. Records will be maintained to identify lack of access trends and for reporting purposes. Check which monitoring activities will be in effect to assure that beneficiary access to care is not substantially impaired. Also, on Appendix IV. C. 2, identify the means the State will employ to intervene to correct problems. If any of the following differ from the State's program, please indicate and explain on Appendix IV. C. 2:

   a. ___ **An advisory committee** will be designated during the phase-in period to address beneficiary and provider concerns.

   b. _X_ **A Hotline** with an 800 number will be maintained which handles any type of inquiry, complaint, or problem.

   c. ___ **Periodic comparison** of the numbers of providers available to the Medicaid recipients before and under the waiver will be conducted. The intent of this review is to identify whether the waiver may have reduced access to specific types of providers. Also, for non-institutional services, a periodic comparison will be made of the individual care givers within an Aentity≅, where applicable, in order to ensure that the same level of access is maintained throughout the waiver period.

   d. _X_ **Periodic beneficiary surveys** (which will contain questions concerning the beneficiaries' access to all services covered under the waiver) will be mailed to a sample of waiver recipients.

e. ___ **Other** (explain on Appendix IV. C. 2. e.)

D. Monitoring Quality of Services: On Appendix IV. D, please explain in detail the State's plans to monitor and assure quality of services under the waiver program. Please describe how will the State monitor the following:

1. **Beneficiaries' reasons for changing providers** in order to detect quality of care problems (not only actual changes, but requests to change specific individual care givers and/or providers);

2. **Hotline**;

3. **Periodic beneficiary surveys** (which question the quality of services received under the waiver) are mailed to a sample of waiver recipients;

4. **Complaints**, grievance and appeals system;

5. **Other** (explain on Appendix IV.D.5.).

E. Other Quality Monitoring:

1. **Quality of Services** will be further monitored through the mechanisms outlined in Appendix IV. E. 1. Quality of services problems identified will result in a desk review or an onsite medical review to resolve the problems.

2. **Periodic reviews**: On Appendix IV. E. 2, please describe what areas will be covered in the State's periodic reviews of claims files and medical audits, including the types of care reviewed and how the problems will be resolved. Please include how often these reviews will take place.

3. ***State Intervention:*** If a problem is identified regarding access to care and quality of services problems, the State *will intervene* as noted below (please indicate which of the following the State utilizes:

   (a) __X__ Education and informal mailing

   (b) __X__ Telephone and/or mail inquiries and follow-up

   (c) __X__ Request that the provider respond to identified problems

   (d) __X__ Referral to program staff for further investigation

(e) __X__ Warning letters

(f) __X__ Referral to State's medical staff for investigation

(g) __X__ Corrective action plans and follow-up

(h) __X__ Change beneficiary's provider

(i) __X__ Restriction on types of beneficiaries

(j) __X__ Further limits of the number of assignments

(k) __X__ Ban on new assignment of beneficiaries

(l) __X__ Transfer of some or all assignments to a different provider

(m) __X__ Suspension or termination as a waiver provider

(n) __X__ Other (explain on Appendix IV. E. 3. n).

V. COST EFFECTIVENESS:

A. **General:** In order to demonstrate cost effectiveness, a waiver request must show that the cost of the waiver program will not exceed what Medicaid's cost would have been in the absence of the waiver. The cost-effectiveness section provides a methodology to demonstrate that the waiver program will be less costly than what costs would be without the waiver.

The State should use its Medicaid fee-for-service experience to develop the cost-effectiveness section of the waiver program. When submitting an initial 1915(b)(4) waiver, the State should estimate the cost of providing the waiver services under the waiver and provide a comparison to the projected cost without the waiver. The costs under the waiver may be estimated based on responses to a request for proposals (RFP) from the potential contractors. The amount of the savings may be estimated based on the discount from the State Plan rates represented by the RFP bids. To project the net savings, the State should add any additional costs associated with administering the waiver, to the projected costs of delivering the waiver services under the waiver. This amount should be compared to the costs of delivering the services without the waiver. All cost comparisons should be made separately for each year of the waiver.

B. ***Rationale for Expected Cost Savings:*** On Appendix V. B., please explain the State's rationale for expected cost reductions under the waiver program.

Include all assumptions made regarding changes due to inflation, utilization rates, State Plan payment rates, and other factors.

C. Format for Showing Savings Summary

(Include supporting documentation, i.e., charts, spreadsheets, in Appendices V.C.)

1. The following schedule shows the calculation of the State's program benefit costs under the waiver (if these are not applicable to the State's methodology, please attach the calculations).

Cost Saving Category	***Costs Expected Without the Waiver***	***Projected Percentage of Cost Savings***	***Total Benefit Savings***
Pharmacy	$ 1,117,992,217		$ 0
Capitated Services	$99,834,686	100%	$ 10,607,243
TOTAL	$1,274,082,734		$10,607,243

2. Costs Under the Waiver

a. Total waiver costs are expected to be $ 1,207,219,661 during the 2-year waiver period. This includes $ 1,199,469,241 in program benefit costs and $ 7,994,683 in additional costs (management fees, administrative costs, bonus payments if any, etc.) which would not have been incurred had the waiver not been implemented.

3. Additional Waiver Costs

The following additional costs are expected to occur under the waiver:

Not applicable

(a) Total additional administrative costs under the waiver, which would not be incurred if the waiver was not implemented, are expected to be $ 7,994,683.

(b) Additional administrative costs are broken down as follows and a brief explanation of each cost item is included on Appendix V. C. 3.(b):

(1) ___ Contract Administration $ 12,280

(2) ___ Systems Modification $

(3) ___ Beneficiary Education, $
Outreach conducted by State employees.

(4) ___ Beneficiary Education, $ ____
Outreach conducted by contracted entity;

(5) ___ Handling Complaints, $ 169,010
Grievances and Appeals.

(6) ___ Utilization Review $
System

(7) ___ Additional Staff $

(8) ___ Hotline Operation $

(9) ___ Quality Assurance $ 62,974
Review System

(10) ___Outreach, Education $
and Enrollment of Waiver Providers

(11) ___Other (explain) $ 7,750,419

4. Costs Without the Waiver

The State projected what the costs would be without the waiver by first calculating the costs during the upcoming fiscal year based on budgeted amounts currently in the 1115 waiver program and projecting fee for service costs in federal fiscal year 1993 for services currently. These cost data were then projected forward a year, adjusting for inflation, to determine what costs would be without the waiver in effect during the proposed 2-year waiver period. The documentation to demonstrate what costs would be in the absence of the waiver is presented in **Exhibit 1**.

5. Program Savings

The schedule below shows how savings were calculated under the waiver:

Year	Cost Reductions Expected Under the Waiver	Minus: Total Additional Waiver Costs	Program Savings
2003	$4,120,500	$3,738,327	$382,173
2004	$6,486,743	$4,256,356	$2,230,387
Total	$10,607,243	$7,994,683	$2,612,560

EXHIBIT #1

Costs Without the Waiver (Refer to number V.C.4. above): (Excludes state administrative costs see Appendix V. C. 3 (b)

Without Waiver	FY 2003 PMPM	FY 2003 Total Costs	FY 2004 PMPM	FY 2004 Total Costs	2 Year Totals
Pharmacy	$238.66 (1)	$497,949,360 (19)	$296.28 (3)	$620,042,857 (21)	$1,117,992,217
Non-Pharmacy	$23.31 (2)	$46,853,100 (20)	$25.32 (4)	$52,981,586 (22)	$99,834,686
Total	$261.97	$544,802,460	$321.59	$673,024,444	$1,217,826,904
Population	167,500		174,399		
Member Months	2,010,000		2,092,788		
Waiver Program	**FY 2003 PMPM**	**FY 2003 Total Costs**	**FY 2004 PMPM**	**FY 2004 Total Costs**	**2 Year Totals**
Pharmacy	$238.66 (5)	$497,949,360 (14)	$296.28 (7)	$620,042,857 (23)	$1,117,992,217
Non-Pharmacy	$21.26 (6)	$42,732,600 (13)	$22.22 (8)	$46,494,843 (24)	$89,227,443
Total	$259.92	$540,681,960	$318.49	$666,537,701	$1,207,219,661
Savings	**FY 2003 PMPM**	**FY 2003 Total Costs**	**FY 2004 PMPM**	**FY 2004 Total Costs**	**2 Year Total Savings**
Pharmacy	$0 (9)	$0 (15)	$0 (11)	$0 (17)	$0 (25)
Non-Pharmacy	$2.05 (10)	$4,120,500 (16)	$3.10 (12)	$6,486,743 (18)	$10,607,243 (26)
Total	$2.05	$4,120,500	$3.10	$6,486,743	$10,607,243

Exhibit 1 Explanations

(1) 2082 data for federal fiscal year ending September 30, 1993 was projected forward using Medicaid National Health Expenditures provided by CMS. Data was not available for 2003, therefore 4% was used. Expenses classified as "Home Heath" and "Other Services" for eligibles 65 and over were divided by the number of eligibles 65 and over.
(2) PMPM values multiplied by member months.
(3) The estimated costs under fee-for-service for 2003 was trended forward using an inflation factor of 9.7%.
(4) PMPM values multiplied by member months.
(5) These costs were determined by actuaries employed by the state. Claims data from October 1, 1999 through September 30, 2001 were used to project per member per month costs projected forward using inflation factors.
(6) PMPM values multiplied by member months.
(7) The capitation costs for 2003 was trended forward using an inflation factor of 9.7%.
(8) PMPM values multiplied by member months.
(9) (1) – (5)
(10) (2) – (6)
(11) (3) – (7)
(12) (4) – (8)
(13) (2) + (4)
(14) (6) + (8)
(15) (13) – (14)

Appendix I

TennCare is a managed care program which covers Medicaid eligibles, as well as certain groups of people who are not eligible for Medicaid. These groups include low income people without access to health insurance and people of any income level who do not have access to health insurance and cannot get it because of a medical condition.

The target population for this 1915(b) waiver proposal is TennCare enrollees who are dually eligible for Medicaid and Medicare, and the intended start date is July 1, 2002. The purpose of the proposed Section 1915(b) waiver is to offer a service delivery vehicle for dual eligibles that is separate from the regular TennCare waiver. Because dual eligibles get most of their services from Medicare providers who are outside the state's Medicaid waiver program, we want to use a separate waiver authority to recognize the costs of providing them with services that are covered by TennCare but not Medicare. These individuals will have access to the same provider network for TennCare services that is available to 1.2 million non-Medicare eligible TennCare enrollees. The state's ability to use its large managed care contractors and their selective contracting strategies for the 1915(b) waiver as well as the Section 1115(a) waiver will enable us to provide better services to this population, with greater cost efficiencies. Medicare cost-sharing will be handled outside the waiver.

TennCare benefits offered under the Section 1115(a) waiver are delivered through state-contracted managed care entities. These benefits, and the entities offering them, are as follows:

1. Most physical health services—Managed Care Organizations
2. Most behavioral health services—Behavioral Health Organizations
3. Behavioral health pharmacy services—TennCare State Pharmacy Program
4. All other pharmacy services for TennCare enrollees who are also eligible for Medicare— TennCare State Pharmacy Program
5. Dental benefits—these are currently offered through the MCOs, but effective September 1, 2002, will be offered through a Dental Benefits Manager

TennCare also covers several benefits provided directly by the state:

1. Long-term care services (services in a NF, an ICF/MR, or an HCBS waiver)
2. Medicare crossover payments (for those enrollees eligible for Medicaid payment of their Medicare cost-sharing expenses)
3. Targeted case management and residential treatment services for children in state custody

Benefits to be offered to this population under the 1915(b) waiver will be identical to those offered under the managed care part of TennCare (see above) and will be offered by the same entities offering these benefits under the managed care program (MCOs, BHOs, TennCare State Pharmacy Program, and DBM). Those dual eligibles who are also eligible for state-delivered TennCare services--long term care, Medicare crossover payments, and/or services for children in state custody--will receive these services just as they do now.

The proposed arrangement will offer the state the opportunity to isolate more specifically the costs and issues involved in serving dual eligibles as a distinct and separate group, rather than as one group among many within the overall Medicaid and TennCare

population. The approach we have chosen ensures no loss in benefits and offers the potential for enhanced care management services for this vulnerable population.

Appendix II.I.4

The population to be covered by the 1915(b) waiver will be persons who are dually eligible for Medicare and Medicaid.

Appendix II.K

The access standards for distance/travel times for recipients to receive services are identical to those contained in the approved Special Terms and Conditions of the TennCare 1115(a) waiver.

Appendix III.A.1

The movement of individuals from the TennCare Section 1115(a) waiver into the Section 1915(b) waiver will be a transparent process for those individuals who are affected. They will have access to the same services, the same providers, and the same service delivery vehicles under the Section 1915(b) waiver that they had under the TennCare Section 1115(a) waiver. They will be advised that their choice of Medicare providers is not affected by their participation in the Section 1915(b) waiver, and they will be reminded that Medicare cost-sharing is handled by TennCare outside all of its waiver programs.

TennCare has three information lines which are available to answer questions from recipients, including recipients who do not speak English or who need other kinds of help in understanding correspondence they receive from the state or the state's contractors. Because there will be no change in how recipients access services, we do not anticipate a large volume of questions.

Appendix III.A.2

The process for allowing enrollees their choice of TennCare providers for TennCare covered services will be identical to the choice processes outlined in the Section 1115(a) waiver.

Appendix III.A.3.(b)

Recipients of this waiver program will receive the same accommodations as those afforded to enrollees in the state's Section 1115(a) TennCare waiver. There are three toll-free hotlines which take calls 24 hours a day. There are TDD lines for the hearing impaired. All materials are published in Spanish as well as English. Persons having special needs because of Limited English Proficiency or disabilities are offered additional assistance upon request.

Appendix III.A.4(f)

Recipients will receive all the educational items that enrollees in the TennCare Section 1115(a) waiver receive. They will get member handbooks and ID cards within 30 days of enrolling in the program. They will also receive quarterly newsletters from the MCOs and occasional mailings from TennCare.

Appendix III. B. I.

Benefits Under the Section 1915(b) Waiver

Note: The 1915(b) waiver will cover services available under Medicaid but not under Medicare. It will also cover services which are available under TennCare/Medicaid after a Medicare benefit limit has been hit, such as medically necessary inpatient hospitalization days in excess of a Medicare beneficiary's 150-day benefit period when a new benefit period has not started and the 60-day lifetime reserve has been used. Medicare cost-sharing is provided for outside the Section 1915b waiver.

Major Non-Medicare Services Covered by the Section 1915(b) Waiver

AMN = As medically necessary

Benefit	Coverage Requirements
Pharmacy* *(see below)*	AMN DESI, LTE, IRS drugs excluded
Non-emergency transportation	As necessary to get enrollee to and from covered services, for those enrollees lacking access to transportation

* *There will be a TennCare cost-sharing requirement for pharmacy services for Medicaid Medicare dual eligibles under this waiver, except for children and residents of long-term care facilities. Pregnancy related services or supplies, emergency situations, and prescribed family planning products are also exempt from copay. The copay schedule is as follows: $1 for generic, multiple source drugs; $1 for brand name, single source drugs; and $3 for brand name, multiple source drugs. There will be an out-of-pocket maximum of $30 per individual per month and $360 per individual per year.*

Medicare "Wrap-Around" Services Covered by the Section 1915(b) Waiver

AMN = As medically necessary.

Benefit	Coverage Requirements
Home health aide services	AMN, with a limit of 125 home health visits per year for persons 21 and older.
Mental health case management	AMN
24 hour residential treatment	AMN
Mental health crisis services	AMN

Appendix C.1

Recipients in the 1915(b) waiver will have the same providers for their TennCare-covered services as persons enrolled in the TennCare waiver. No efforts will be made to restrict recipients' choice of Medicare providers.

TennCare services will be delivered through Managed Care Organizations, Behavioral Health Organizations, a state-administered pharmacy program, and a Dental Benefits Manager. Providers enrolled in each of these managed care entities must meet all the requirements for providers in the TennCare waiver. The state has a process in place for restricting the enrollment of any health plans which do not meet the state's qualifications. This process results in choosing the most cost effective and efficient providers of service.

Appendix IV.B

Complaints and grievances under the 1915(b) waiver will be handled in exactly the same manner as complaints and grievances under the TennCare Section 1115(a) waiver.

Appendix IV.C. 1.

Access to services offered under the 1915(b) waiver will be monitored in exactly the same manner as services offered under the TennCare Section 1115(a) waiver.

Appendix IV.D

Services offered under the 1915(b) waiver will be monitored for quality in exactly the same manner as services offered under the TennCare Section 1115(a) waiver.

Appendix IV.E.3.n

Services offered under the 1915(b) waiver will be monitored for quality in exactly the same manner as services offered under the TennCare Section 1115(a) waiver.

Should problems be identified with access to care or quality of care, the state's strategies for intervention are identical to those employed under the Section 1115(a) waiver. The state's contract with its managed care entities outlines a range of sanctions which may be employed, from requests for corrective action to assessment of liquidated damages to termination of the contract. Each managed care entity receives an annual assessment by an External Quality Review Organization, which is then followed up with requests for corrective action where deficiencies are noted. In addition, the Bureau of TennCare has a Quality Improvement Unit which performs certain focused reviews and special studies and works with the managed care entities to correct problems found. There is also an Office of Contract Development and Compliance with oversees monitoring of the contracts and coordinates follow-up when problems are identified. Problems with access to care or quality of care may also be identified through the TennCare Solutions Unit, which is the place people call with complaints and requests for appeals. These problems are directed to the appropriate unit at TennCare for investigation and action.

Appendix V.B

The state will achieve cost savings using managed care techniques. A co-payment will be introduced for pharmacy benefits. Savings is achieved by capitating non-pharmacy services. Expenses classified as “Home Heath” and “Other Services” for eligible people 65 and over were divided by the number of eligible people 65 and over were retrieved from 2082 data for federal fiscal year ending September 30, 1993. This was used to approximate the fee-for-service costs from the last federal fiscal year prior to the implementation of the 1115 waiver. A pmpm amount was derived and projected forward using Medicaid National Health Expenditures provided by CMS. Data was not available for 2003, therefore 4% was used. This projected fee-for-service cost was compared to the capitation rate developed for the current 1115 waiver and demonstrated a savings of $2.05 pmpm. These savings are achieved trough efficiencies in managed care including medical management and selective contracting.

Appendix V. C. 3. (b)

(1) A portion of the cost of the Office of Contract Development and Compliance has been allocated to monitor the managed care contracts. This allocation is based on the ratio of MCO capitation expenditures for enrollees dually eligible for Medicaid and Medicare to the overall MCO capitation expenditure for the population enrolled in MCOs.

(5) Handling Complaints, Grievances and Appeals - A portion of the cost of the legal staff cots and appeals staff costs has been allocated to this waiver due to appeal processing and hearings. This allocation is based on the ratio of MCO capitation expenditures for enrollees dually eligible for Medicaid and Medicare to the overall MCO capitation expenditure for the population enrolled in MCOs.

(9) Quality Assurance and Review - A portion of the cost of the Office of Quality Oversight has been allocated related to the performance of quality assurance activities. This includes a contract with at vendor to perform annual on-sight reviews of the activities of the managed care plans. This allocation is based on the ratio of MCO capitation expenditures for enrollees dually eligible for Medicaid and Medicare to the overall MCO capitation expenditure for the population enrolled in MCOs.

(11) A management fee will be paid on per member per month basis to contracted health maintenance organizations. This fee is to cover costs of managing the non-pharmacy benefit package including maintaining provider networks, beneficiary education, medical management and other contractually required activities.

Administrative Costs	Current Costs	Allocation %	Year 1	Year 2	Total
Contract Administration	$495,200	1.22%	$6,049	$6,231	$12,280
Appeals	$6,815,250	1.22%	$83,256	$85,754	$169,010
Quality Assurance	$2,539,400	1.22%	$31,022	$31,952	$62,974
Management Fees			$3,618,000	$4,132,419	$7,750,419
Total			$3,738,327	$4,256,356	$7,994,683

Management Fees	FY 2003 PMPM	FY 2003 Total Costs	FY 2004 PMPM	FY 2004 Total Costs	Total Two Year Costs
	$ 1.80	$ 3,618,000	$ 1.97	$ 4,132,419	$ 7,750,419

Management Fees were determined by actuaries. Year 2 administrative costs increased 3% for inflation.